VULNERABLE POPULATIONS
FINDINGS AND RECOMMENDATIONS

I. INTRODUCTION

"*As members of human communities, we are all potentially vulnerable*"[1]
LuAnn Aday

"*Better-integrated and better-organized systems of care promise potentially high quality and effective care, but only if a commitment is made at the outset to strong quality assurance, a service ethic that cares for the whole person, and outreach to those in the community who are most in need.*"[2]
Joyce Dubow

A. Definition of Vulnerable

Serving the special needs of vulnerable populations creates a unique challenge for managed care organizations, be they health plans or provider organizations contracting on a prepaid capitated basis. Managed care does have a great potential for better serving vulnerable beneficiaries by providing more effective management, coordinating multiple medical and social services, and exercising greater flexibility in providing the care that beneficiaries may require.[3] However, the capacity of a plan to provide appropriate care for persons with chronic or complex illnesses and circumstances depends to a large extent on the way the plan is organized and financed. Appropriate staffing and coordination of services is as critical to quality of care as is adequate risk adjustment to the financial stability of plans.

Traditionally society has recognized vulnerable individuals and groups and supported public health and treatment-oriented programs and services to address their needs. The interface of managed care plans with the public health and other safety-net providers for at-risk persons is of major concern for all vulnerable groups. In this paper we make recommendations that apply to all vulnerable populations, and that are specific to populations that receive care through government's contractual relationships with providers.

As government payors move larger portions of Medicare and Medicaid beneficiaries into managed care, the need to address safeguards for vulnerable populations has come to the collective forefront of federal and state policy makers' agendas. At stake is the health status of beneficiaries who have come to rely on regulatory safeguards and governmental oversight to protect their general interest through contractual requirements negotiated with managed care health plans.

The movement of significant beneficiary pools from fee-for-service to managed care also has an effect on the commercial health plan industry and the provider community. Commercial and public health plans participating in Medi-Cal and Medicare must make significant investments in

[1] Aday, LuAnn, At Risk In America: The Health and Health Care needs of Vulnerable Populations in the United States, 1993.
[2] Dubow, Joyce, Medicare Managed Care: Issues for Vulnerable populations, Public Policy Institute of the AARP.
[3] Interview Dr. Helen Rodriguez-Trias, Taskforce Member and Mary Dewane, CEO CalOPTIMA.

provider network development, information systems, and clinical quality and utilization management. Medi-Cal contracts require greater access, improved quality, and enhanced choice. These demands, place at risk an entire safety-net system of care which might not be able to manage the transition cost. At greatest risk is the county health care infrastructure. Counties may be unable to compete for members who may, for the first time, be presented with recognizable choices, not just of health plans but of private and public delivery systems.

The true power of the payor to cause the managed health care industry to change has been greatly enhanced by the sheer size of the populations being moved into prepaid health plans. The impact on the behavior of both public and private health systems now thrown into direct competition for health plan membership will be significant.

Within these specially funded health care programs there are a number of special need and vulnerable populations, some of whom are highlighted in this report:

- Frail elderly
- Disabled adults
- Disabled children
- High risk pregnant women
- Foster children
- Chronically ill, HIV/AIDS
- Socially and economically disadvantaged, culturally isolated
- Suffering mental illness
- Chemically dependent

These populations present a unique challenge to managed care organizations and, to a great degree, will serve as the publics' litmus test as to whether managed care can and will be the principal model of health care delivery beyond the year 2000.

B. Findings for Vulnerable Population in Managed Settings

The results of Miller and Luft's recent study[4] on managed care versus FFS performance indicates that HMOs produce better, the same, and worse quality of care depending on the particular organization and particular disease. However, three of the five observations with significant negative HMO results focus on chronically ill, low-income enrollees in worse health, impaired or frail social health maintenance organization (SHMO) demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While it is true that some quality of care results that show better or mixed HMO quality are also at least partially based on data for patients with chronic conditions and diseases, and that there are many valid cautions against over-interpreting the results, the fact that three significantly negative HMO quality of care results for Medicare HMO enrollees with chronic conditions and disease warrants attention. In addition, based on the interviews with the many advocates and foundations contributing to this report, managed care seems to present the following challenges that need to be addressed in serving these populations:

[4] Miller and Luft, Does Managed Care Lead to Better Or Worse Quality of Care?, *Health Affairs*, September/October 1997.

- Under-treating patients with chronic illness
- Restrictions in seeking specialists
- Lack of expanded systems of care and limited benefits definition
- Discontinuity of treatment
- Lengthy time frames for authorization
- Lack of consumer understanding
- Providers' failure to diagnose accurately

II. RECOMMENDATIONS

An overarching principle of all the recommendations referring to vulnerable populations is acknowledging that they are the best and most effective advocates and arbitrators of their own care. Best practices must be based on their inclusion in decision making, standard setting, and quality improvement.

A. Assurance of Access, Quality, Benefits, and Consumer Protection

Several recommendations that relate to assurance of access, quality, benefits, and consumer protections for vulnerable populations appear in other ERG papers and are referenced in brackets below.

Special Note: For those recommendations below where the intent and spirit of the recommendation is captured adequately by an existing recommendation this will be so noted. For those recommendations below where a friendly amendment is required to adequately reflect the intent and spirit of the recommendation this will be so noted and the friendly amendment quoted.

1. [Recommendation for allowing specialist PCPs for members with specific illnesses will appear in the Physician-Patient paper and be referenced here with proper wording.]
2. [Recommendation for adjusting payments to providers for quality will appear in the Provider Incentives paper and be referenced here with proper wording.]
3. [Recommendation for working with vulnerable populations to adopt or build upon existing quality methodologies and indicators will appear in Consumer Involvement paper and be referenced here with proper wording. Friendly amendment made to recommendation about pilot studies that will be conducted to expand and enhance comparative performance analysis to ensure active participation by vulnerable in pilot process. With amendment recommendation would read, "These research entities should involve appropriate stake-holders (including providers, consumers including representatives of vulnerable populations, plans and medical groups/IPAs and health policy experts) in designing and evaluating the pilot studies."]
4. [Recommendation for implementing risk adjustment will appear in Risk Adjustment paper and be referenced here with proper wording.]
5. [Recommendation for achieving consensus on the definition of medically necessary and appropriate and incorporating the concept of maximizing functional capability will appear

in the Improving the Delivery of Care and Accountability in the Practice of Medicine paper and be referenced here with proper wording.]

6. [Recommendation for communicating clearly to enrollees the type of HMO, coverage, formularies, customer satisfaction, and customized quality measures will appear in the Consumer Information paper and be referenced here with proper wording.]
7. [Recommendations for not only providing written evidence of coverage and membership handbooks, but assuring enrollees' understanding of coverage, member rights, and benefits will appear in Standardizing Health Benefits and Consumer Information papers and be referenced here with proper wording.]
8. [Recommendation for allowing advocates to assist in navigating the administrative or clinical grievance processes of the plan or developing omsbudsperson programs to assure members' rights are protected will appear in Dispute Resolution paper and be referenced here with proper wording.]
9. [Recommendation for establishing advisory committees with representation from health care professionals, advocacy groups, and consumer representatives for vulnerable populations will appear in Consumer Information paper and be referenced here with proper wording. With amendment recommendation would read, "These committees shall communicate and advocate for members' needs and serve as a resource for the governing body…They shall be responsible for establishing mechanisms and procedures for enrollees to express their views and concerns about the HMO/plan. These committees should include representatives of vulnerable populations."]
10. [Recommendation for incorporating multimedia education and other innovative techniques to ensure user friendly member education will appear in Consumer Information and be referenced here with proper wording. With amendment recommendation would read that the publication "should be produced at a simple enough reading level and in sufficient formats and languages (including video and multimedia formats) so that it is useful to the great majority of consumers. The publication should be tested and evaluated with consumer to determine that it is understood by and useful to consumers."]

Special Note: The intent of the following recommendations may have been captured in other sections of the report. If the existing recommendation is not judged to be sufficient, a new amendment will need to be proposed.

11. The language of the recommendation in the Standardizing Health Benefits paper was revised to ensure vulnerable populations are actively involved in the development of all five standard reference coverage contracts. The recommendation currently states that a standard outline and definitions of terminology for the standard reference package should be developed by a working group comprised of "all major stakeholders such as employers, health plans, purchasing organizations, small and large providers, representatives of vulnerable populations and consumer organizations." This recommendation could be referenced here and act as a substitute for the idea that the state should ensure that 3 of the 5 standard reference coverage contracts meet the expanded benefit needs of vulnerable populations currently in the original Vulnerable Populations paper.
12. A recommendation is made in the Improving the Delivery of Care and Accountability in the Practice of Medicine paper for revision to prior authorization that would enhance

providing services consistent with recognized clinical guidelines and community standards germane to specific medical quality and access. This recommendation could be referenced here and act as a substitute for the idea that plans provide services consistent with recognized clinical guidelines and community standards germane to specific medical quality and access currently in the original Vulnerable Populations paper.

13. Recommendation for writing contractual arrangements that enable chronically ill, acutely ill, or pregnant women to continue seeing their doctors, unless removed for poor quality will appear in the Physician-Patient Relationship paper. However the specified duration for continuity reads "until the course of treatment (or postpartum care) is completed up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transition to a new provider," rather than "for an extended period of time" as is currently stated in the original Vulnerable Populations paper.
14. The recommendation for "ensuring that capitation rates are appropriate to the expected level of medical risk" was discussed but not approved by the Task Force as part of the Provider Incentives paper. What was approved was disclosure of scope and method of compensation.

In addition, the Task Force makes the following additional recommendations essential for serving vulnerable populations effectively in managed care settings.

15. State to contract with those health plans that are currently able to or agree to work towards implementing the ability to identify and track their vulnerable populations, and report technologically feasible performance outcomes for these populations.

    (a) State should provide incentives for plans to implement effectively by withholding a percent of the premium and paying plans on a sliding scale based on performance.
    (b) State should work with other large purchasers (e.g., PBGH) to develop common contract standards for plans to track, identify, and monitor performance outcomes for all vulnerable populations.

16. State to contract with those plans that agree to pay for appropriate care from qualified out-of-network provider if plan does not include specialty provider qualified to treat enrollee's condition. (See similar recommendation regarding payment for second opinions in the Dispute Resolution paper.)
17. State to contract with those plans that demonstrate integration of acute and long-term care services, as well as linkages to social services in community.
18. State to require and monitor plans compliance with federal and state nondiscrimination and accessibility standards as a condition for retaining their license to operate.
19. State to contract with those plans that currently or agree to work towards credentialing and certifying medical groups and providers based on their knowledge, sensitivity, skills, and cultural competence to serve vulnerable populations.
20. State to require and monitor prohibiting discharge of enrollee or placement of enrollee in any institutional setting without informed consent. *Special Research Point: This*

statement conflicts with existing law and would not be possible with individuals who are not competent. The Task Force may wish to consider revising language.

B. Future Reallocation of Health Care Costs Avoided through Managed Care or Other Funding Sources to Improve the Quality of and Access to Care for Vulnerable Populations

1. State to fund, possibly by allocating a portion of the billions of dollars in avoidable costs attributable to Medi-Cal selective contracting and CalPERS managed care, to improve access to or quality of care for vulnerable populations. Examples of programs that would meet this recommendation include expansion of coverage for California's uninsured and/or upward adjustment of Medi-Cal contract rates to cover more adequately costs for serving these populations.

C. Application of Recommendations to the Medi-Cal/Medicare Populations

Recommendation C was briefly discussed, however research was requested to determine what DHS was currently doing in regards to tracking and reporting data, and the work effort that would be required to execute sub-recommendations 2-4 presented below.

1. State to require that Medi-Cal managed care plans and managed care plans serving Medicare patients in California be governed by all recommendations in all sections of this Task Force report.

In addition to those protections, Medi-Cal consumers, millions of whom are in the process of being mandatorily moved into managed care plans, require special oversight. The legislature, therefore, should require that the Department of Health Services (DHS) report annually on the status of the impact of Medi-Cal managed care. An understandable report form of the relevant summary data compiled by DHS should be turned over to the legislature annually and made available to interested publics. Most of the data required in recommendation 2 below is already collected for Medi-Cal populations, but the Task Force recommends a collaboration between DHS and CCHRI to provide comparisons between the Medi-Cal and commercial populations and the presentation of this data in an easy to read format. The data required in recommendations 3 and 4 is not currently being collected.

2. DHS should prepare an annual report for the legislature and interested public on the quality of and access to care for Medi-Cal consumers and include the following topics:

   (a) A comparison of the performance of plans within each Medi-Cal managed care county as well as among counties
   (b) A comparison of provider panels among plans and between private pay and Medi-Cal commercial plans
   (c) A comparison of access, quality, and cost indicators for Medi-Cal managed care patients with privately insured patients in California
   (d) An evaluation of Medi-Cal consumers' 1) understanding of 2) use of and 3) access to managed care plans

(e) An analysis of the effectiveness of translated materials and the ability of plans to serve multi-lingual and multi-cultural consumers

(f) An analysis of provider continuity including analysis of impact of changes in Medi-Cal eligibility

(g) An analysis of patterns of default and disenrollment

3. DHS should prepare an annual report for the legislature and interested public on the impact of Medi-Cal managed care on the capacity of the public health system and other safety-net entities to provide care for uninsured patients. This should include county-by-county analyses of changes in access and quality for uninsured patients as well as analyses of changes in the institutional capacities of safety-net providers.
4. DHS should prepare an annual report for the legislature and interested public on the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health including their capacity to track epidemiological trends and to do population-based health education.

Special Note – DHS response to recommendations in terms of status. Task Force staff have also requested an estimate of the work effort to implement and execute those recommendations not currently being performed.

Recommendation 2 – All sub-recommendations (a-g) related to the assessment of quality and access to care are already being addressed or are planned to be addressed in the near future. The federal government mandated that EQROS (External Quality Review Organizations) be established as of June 1997 to evaluate the quality of and access to care provided to Medi-Cal beneficiaries, compare performance to national standards and other plans, and develop benchmarks. These groups are also required to assess how individual plans perform their own internal quality improvement studies, and make recommendations for improvement. EQROS would be responsible for sub-recommendations a-c. In addition to the studies of the EQROs, in certain cases existing programs are already in place to monitor access to and quality of care. HCFA is currently implementing a pilot project using patient satisfaction surveys and a focus study methodology to assess consumer understanding and recommend improvements. Analysis of eligibility changes and the impact on provider continuity is currently monitored and the responsibility of the contract managers, and analysis of patterns of default and disenrollment is currently monitored through the ombudsperson program.

Recommendation 3 – An assessment of the impact of Medi-Cal managed care on the capacity of the public health system and other safety-net entities to provide care for uninsured patients is not currently being done. However, Medi-Cal formally recognizes the role of the safety-net provider in caring for the uninsured, and one of its stated goals in the Medi-Cal managed care implementation is preservation of the safety-net provider. Medi-Cal attempts to provide support to the safety-net through establishment of the local initiative as a plan under the two-plan model and extra points are awarded during selection to those commercial plans that include safety-net providers as part of their network. Medi-Cal realizes that access to the network is not the same thing as access to patients, and Medi-Cal is currently looking at how to work with safety-net providers that are

losing beneficiaries, for example, how the expansion of the Healthy Families Program might expand the beneficiary pool for these providers.

Recommendation 4 – An assessment of the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health is not currently being done. However, Medi-Cal recognizes the important role these entities play in providing community-based, wrap-around services not offered by the plans themselves, and requires plans to draft formal memorandums of understanding with these entities (e.g., Department of Public Health, CHDP, CCS, mental health providers, etc.). The memorandums ensure linkages are established between the plans and the public health entities, and that they are working in concert with each other to care for beneficiaries.